Group Psychotherapy With Adolescents

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■ *In working in a large general hospital with groups of disturbed adolescent patients from economically and emotionally deprived walks of life, therapists worked out a plan of outpatient group therapy that in general has had good results as measured by effective living and functioning in school, at home and with peers. Groups were limited to eight patients and meetings were held once a week with two co-therapists of different sexes. Therapists usually did not try to turn discussions in one direction or another. More active than in usual group work, the therapists did not hesitate to be didactic or educational as the topic or problem indicated.*

At termination of the group sessions, usually at the end of a school year as a natural time of leave-taking, the members who had benefited sufficiently faced the departure with little emotional wrench; those who had not were resentful, anxious, disappointed or relieved.

THERAPISTS IN THE psychiatric outpatient service at Los Angeles County General Hospital have evolved a plan of group therapy for adolescent patients that has brought good results.

The Los Angeles County General Hospital, one of the largest hospitals in the world, has a psychiatric unit in which there is an inpatient children's service and an inpatient adolescents' service. There is an active, large psychiatric outpatient unit for children and adolescents. All the children's psychiatric services are integrated into one unified service, permitting an extraordinary flexibility of service and training.

The hospital is located in East Los Angeles, a marginal area with a population of Mexican origin, Negroes and lower class Caucasians. Many families are on public assistance. Broken homes, parental desertions and multiple marriages are frequent. Clinic experiences for many of these families have not been pleasant or rewarding for them. It is only in recent years with the impact of many agencies working in such areas that families seek psychiatric help without the pressure of the school or the Bureau of Public Assistance.

The author's special interest in adolescents was well known in the community; and this, in addition to a newly opened Adolescent Ward, led to increased referrals to the clinic. Our interest was evident in the processing of the families and their young people. Feeling a special responsibility toward families of the kind described above, we tried to "hang on" to them in every way we could.

That the adolescent period is a fascinating one, and one that is receiving increasing attention, is readily apparent. There is no clear-cut definitive technique for treating adolescents either individually or in group therapy. The approaches vary according to many factors—milieu, administrative expectations, whether the setting is a residential or psychiatric hospital or an outpatient clinic or private practice. Such factors have a bearing on

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the goals and on the kinds of disturbances encountered. Nonetheless, all adolescents have a common bond and common problems to master even if therapists do not have a common agreed-upon technique.

All adolescents have to master reawakened oedipal fantasies; to emancipate themselves from the dependent position that is much complicated by prolonged, enforced social and economic dependency of today; to achieve a sense of identity, of "who I am," with a beginning commitment to a life style and goal which society will recognize; to achieve a heterosexual orientation; to develop standards, ethics and a morality on their own. Many forces may interfere with the achieving of the psychological maturity to cope with these tasks, yet to move across adolescence to psychological maturity requires that the job be done.

It seems that for adolescents group therapy should be a natural therapeutic approach, for aren't adolescents group minded, influenced by their peers and peer group standards? We sometimes forget that while this is so, the intrusion of an adult in a special role sets up other forces, for any adult statement is a criticism to the adolescent, particularly the younger youth whose defenses are so fluid. Slavson, in a discussion, once called this the "paranoia" of the teenager. Nonetheless, any measures that free the youth to become more effective so that healthy maturation can occur are a form of therapy.

A group therapy way of working with outpatient adolescents has evolved at the Los Angeles County General Hospital. All prospective candidates for the group are seen first by one of the group therapists. In the clinic process parents must apply; hence much data are obtained from parents and other sources, which, of course, help in evaluating the young person clinically.

Group Composition

To give an example of the group therapy method that has evolved, this paper will focus on a group of girls. The age range was about 15 to about 17 years of age although if the maturity of a youth was such that she could fit into the group, the chronological age was no barrier. Thus, in one group there was a bright, well developed girl of 13 and an 18-year-old whose maturity was considerably less. As a rule, however, an attempt was made to keep within the age range because of the more frequent common interests and inner psychological states. The size of the group was limited to eight as a workable number. No one was accepted for the group unless motivated for help; none were coerced into the group except implicitly (the group offering the only therapy available). Some needed individual help before entering the group; some of the sicker ones needed support outside the group, even brief periods in hospital.

The diagnostic categories varied from adjustment reaction to borderline psychosis, and in one instance included a hallucinating schizophrenic girl who had sufficient islands of reality. Groups were of one sex. (In mixed groups there was interference in exploring sexual material in a significant, meaningful way. Also, the mixed groups tended to be overstimulating experiences, interfering with group work. This may be true particularly of the hospital groups because of a usual history of early sexual experiences.)

The groups were perforce open-ended. Thus, young people were present for varying lengths of time and new members were added as others departed. On the average each youth spent at least a year in the group which met once weekly for an hour and a half. While it is not economical or always practical, it is best if there are two co-therapists of opposite sexes. The family, transference and identification implications are thus much enlarged. Incidentally, most of the parents of the adolescents are worked with either individually or in groups. The co-therapists met periodically with the staff working with the parents.

The Therapist

Not everyone can do group therapy, nor can everyone who does group therapy work with adolescents. The therapist working with adolescents must have a thorough knowledge of the adolescent era, of the normal adjustive devices and defenses of adolescence, of the adolescent as a person, and of group process. Unless he has a genuine respect and liking for young people, there is difficulty. Unless he is aware that parents are people too, there is difficulty. Unless he has a sense of humor and much tolerance, the role of the therapist can be onerous.

The therapist represents an adult who has many roles, and many roles are thrust upon him. He represents reality, authority, educator. And in his very person and attitudes—which are quickly "read" by the group—he represents values, ideals, standards, ethics, morals. If the population of the

group is from the lower classes or lower middle classes, it is essential that he understand the special social, familial and cultural milieu of the group members which may affect the goal one has for the group or a group member.

To the therapist, all that happens in the group has meaning whether the talk is of hats or dresses or is of the so-called "idle" kind. He has to become sensitized to the youth's talk and language and listen not only to the manifest content but the underlying emotional attitudes expressed.

The male therapist should be dominant in the group. Most of the girls in the groups here discussed had no father at home or in some Negro families the mother was very strongly dominant. Girls test their femininity and acceptance of the female role on their fathers, and a dominant male figure interested in them helped with this task as well as to establish the image of the male as something other than non-existent or in the shadowy background.

Group Structure

The youths selected and willing to participate in the group already had contact with one or the other group therapist in the evaluation process. Preparation for the group took place in these initial individual sessions with the simplest explanations that essentially "we were all to work together." The meeting time was scheduled to be most convenient for all, which meant that it was really a little inconvenient for everyone and that most young people had to take off a half day from school.

Many approaches were tried to initiate the group, such as greeting each one by name, while the therapist observed how they became acquainted; or asking each one to identify herself, the therapist observing the acquaintance process. An approach found to be valuable is to point up that each one came voluntarily for help and to ask each what she hoped the group could do to help her. This often led to a facilitation of a group feeling in that their interdependence and the assistance of one to the other were usually reiterated. An introduction now being used is for the therapist to ask each one not only to identify herself but to state as well as she can and as much as she can of the problems for which she wishes help. The procedure is followed for each newcomer admitted to the group, even though it temporarily interrupts the group work. All members of the group knew that the therapists knew the presenting problem.

Once members of a group were in the meeting room they were expected to stay until the meeting was over. Not once in a number of years has a youth walked out. There are no distractions such as radios, objects of art or the like. The furniture is comfortable chairs, a table and ash trays. The attitude in the meetings is that anything can be said, rather than done, and the confidential nature of the material discussed during the sessions is stressed. It was fascinating to see how the young people did indeed keep private what was divulged —even that one of the members was pregnant.

Implicit in the group structure was the understanding that the therapists would deal with the school authorities, police, parents or employers when reality circumstances so demanded. Implicit also was the expectation that the group would set the pace and the controls for the discussions, but that if they needed direction in this discipline, the therapists would help. The effect of this structure was a feeling of safety and security, an implicit promise they would be helped, that indeed there were solutions to problems and that adolescents could be understood and could understand.

A fortunate accident was turned to therapeutic advantage. Until a new clinic building was available, the first meetings of the group were in an office of the inpatient children's service, a locked ward. The office was locked to keep the children out and insure some privacy. Probably this helped the expectation that no one would leave. After the group meeting, the members expressed a desire for something to eat or drink. All wandered into the ward kitchen and each one had chocolate milk. It became an accepted ritual at the end of each meeting to go to the kitchen for chocolate milk, regardless of how difficult the session might have been. So, no matter what was expressed in the session, the "parents" loved and fed the child the symbol of love.

Group Process

In general, the therapist in adolescent groups is more active than therapists in adult groups. Depending upon the group composition at the time and the problems with which the group is working, the therapist may well be an educator. For example, in the group of girls, questions arose about sexual differences and sex anatomy. Diagrams were used to illustrate—and educate—and

from this role the therapists stepped back and sexual fantasies and anxieties came to the fore. Questions arose about contraception. Information was given. Questions about sexual relations were answered, with group discussion focusing on what it meant to the girl to have them and what it meant to her that the boy cared not at all about contraception and was perfectly willing for her to risk pregnancy.

Since there was so much work to do with adolescent patients, it did not matter where the group started—whether with personal problems or with discussions of race riots, the elections or various kinds of occupations. After all, any assistance that frees anxiety-bound energy frees energy for the task of maturing and the growth of the personality.

The question of facilitating the group process was examined. The stay in the group was usually from September to June, with a summer break; and although it was an open-ended continuous group, not often did a girl return the following September unless she had begun late in the year. The therapists felt that they had two tasks to carry out in this period of nine or ten months: (1) Helping in the group process with the presenting problems of the youths—problems which prevented them in many instances from dealing with the psychological work of adolescence; and (2) helping with the psychological work of adolescence, although in many of them this could proceed if they were freed sufficiently of pathological defenses and constricting, inhibiting anxieties.

With these tasks and the time limits in mind, the therapists worked out a general plan that has been followed with good results as measured by effective living and functioning in school, at home or with peers. It was found that by making use of the presentation of problems by the group as a starting point, the therapist could turn the discussion in such a way as to help the members with problems of dependence-independence, of sexual anxiety and orientation, of identity and goals, of sibling and parent relations, of peer relations and others. Sometimes the group readily took up such discussions. But if they backed away, as sometimes they did, the therapists could be didactic, raising questions applicable to the problems of all adolescents—not just the specific problems of group members. Usually that did not "push" the group to a discussion of the subject. Yet, in later follow-up, it was found that the young people graduating from the group remembered most how supportive and "freeing" such information had been to them. Adolescence is a unique era. The adolescent struggles with his uniqueness and gains much relief from sharing with his peers the universality of their questions, doubts, feelings and troubles. Intrusion of the therapists' discourses into the group meetings had the effect of showing the members that they did share these problems.

Termination

Since the staff had learned that the summer break was so common an ending period, plans were made for a rounding out and termination of the therapy at that time.

The approaching recess was a legitimate occasion for discussing plans for the vacation and for feelings about leaving the group and one another. Those who were ready to leave, who clinically showed improvement, felt secure enough to discuss leaving their group "siblings" and "parent" figures with confidence that the siblings and parents would not lose interest in them or cease to be available for help. The secure members could make a normal separation much as a healthy youth does when leaving home for school or camp. Others expressed anger at the recess, or relief that the sessions were ending; and some said that it was too good to be true to have any stable family, or that it was too anxiety-producing to get as friendly as they had been. Those still insecure said such things as "What's the use, nothing really lasts"; "You can't count on anyone or anything"; "People aren't interested in you really"; Doctors take vacations when they want to, no matter what the patient needs." Patients of this order frequently separated from the group prematurely—before the therapists thought they should.

When problems about termination and separation were introduced, the therapists did not hesitate to voice sentiments and feelings if the group was unable or hesitant to articulate them.